Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY GROUP
P O BOX 29407
SAN ANTONIO, TX 78229-5907

Respondent Name
SENTINEL INSURANCE COMPANY LTD

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-2384-01

MFDR Date Received
MARCH 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were given Cigna at time services were rendered. It was not until 10/05/2011 that we received patient's workers compensation information. Per TDI-DWC Rule §133.20 we had 95 days from the time we were notified of Workers Compensation Insurance to file this claim."

Amount in Dispute: $62.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "no record of receipt of a legible copy prior to 1/26/12…At initial and subsequent submissions, provider did not submit proof as outlined in Labor Code: 408.0272(b)(1), to support extension of the 95-Day Rule was warranted Please see attached."

Response Submitted by: The Hartford, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2011	73110-26, 73610-26, 71101-26, 73110-26-76	$62.07	$62.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 1, 2012

- 29-The time limit for filing has expired. Per Texas Labor Code 408.027 Bills must be sent to the carrier on a timely basis, within 95 days from the dates of service.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. Per …28 Tex. Admin. Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that §408.0272 applies to the service in dispute, for that reason, the health care provider and requestor in this dispute were required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Tex. Admin. Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.
2. Per Texas Labor Code §408.0272(b)(1)(B) & 28 Texas Administrative Code §408.0272 (c) state: (b) Not withstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027 (a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee.; (c) Not withstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim.
3. Review of the submitted documentation finds that the requestor provided a copy of a "Provider Explanation of Medical Payment Report" they received from Cigna. This documentation supports that the requestor submitted the disputed bill to the incorrect insurance carrier. Furthermore, the requestor submitted a copy of the "Inquiry-Patient Notes" which support that workers' compensation information was provided to the requestor by the injured employee on October 5, 2011. The requestor states they billed the respondent and received a letter dated October 26, 2011 which stated that they were unable to process payment because the invoice was illegible. The requestor provided a letter which supports that on November 16, 2011 they resubmitted a legible claim for reconsideration.
4. Per the Texas Labor Code §408.0272(b) (1)(B) & 28 Texas Administrative Code §408.0272 (c) the requestor's documentation supports that a bill was submitted to the correct insurance carrier within 95 days from the date they were notified of their erroneous submission to Cigna. Therefore, requestor is entitled to reimbursement as follows:

   CPT Code 73110: 54.54 WC CF/33.9764 Medicare CF x $8.66 Participating amount = $13.90 x 2 = $27.80.

   CPT Code 73610: 54.54 WC CF/33.9764 Medicare CF x $8.34 Participating amount = $13.39. The requestor is seeking $13.38. This amount is recommended.

   CPT Code 71101: 54.54 WC CF/33.9764 Medicare CF x $13.02 Participating amount = $20.90. The requestor is seeking $20.89. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $62.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $62.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		12/20/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.